



STATE OF MARYLAND

Dhmmh

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October 12, 2012

Public Health & Emergency Preparedness Bulletin: # 2012:40 Reporting for the week ending 10/06/12 (MMWR Week #40)

CURRENT HOMELAND SECURITY THREAT LEVELS

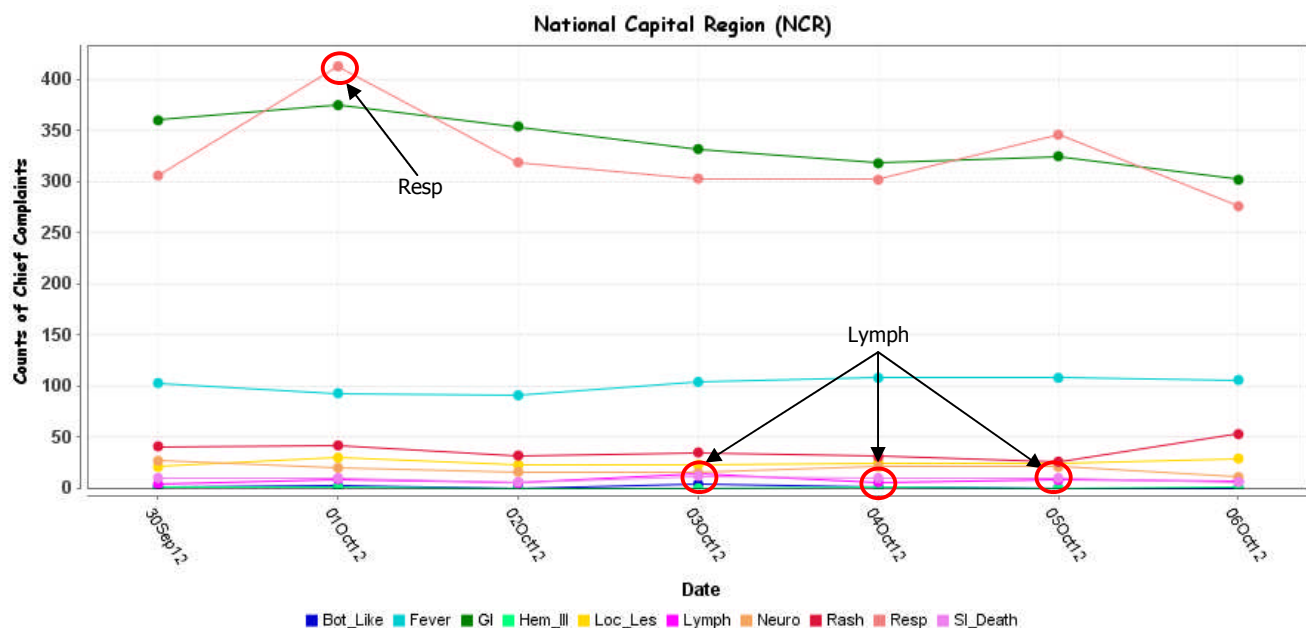
National: No Active Alerts
Maryland: Level One (MEMA status)

SYNDROMIC SURVEILLANCE REPORTS

ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):

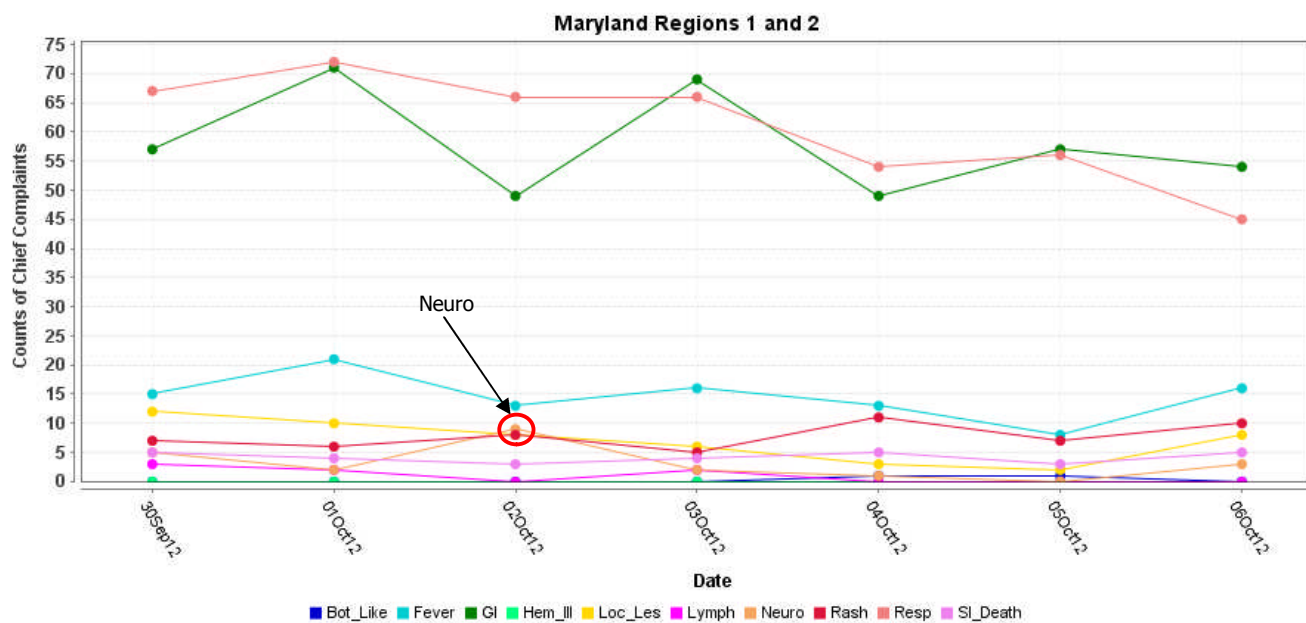
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

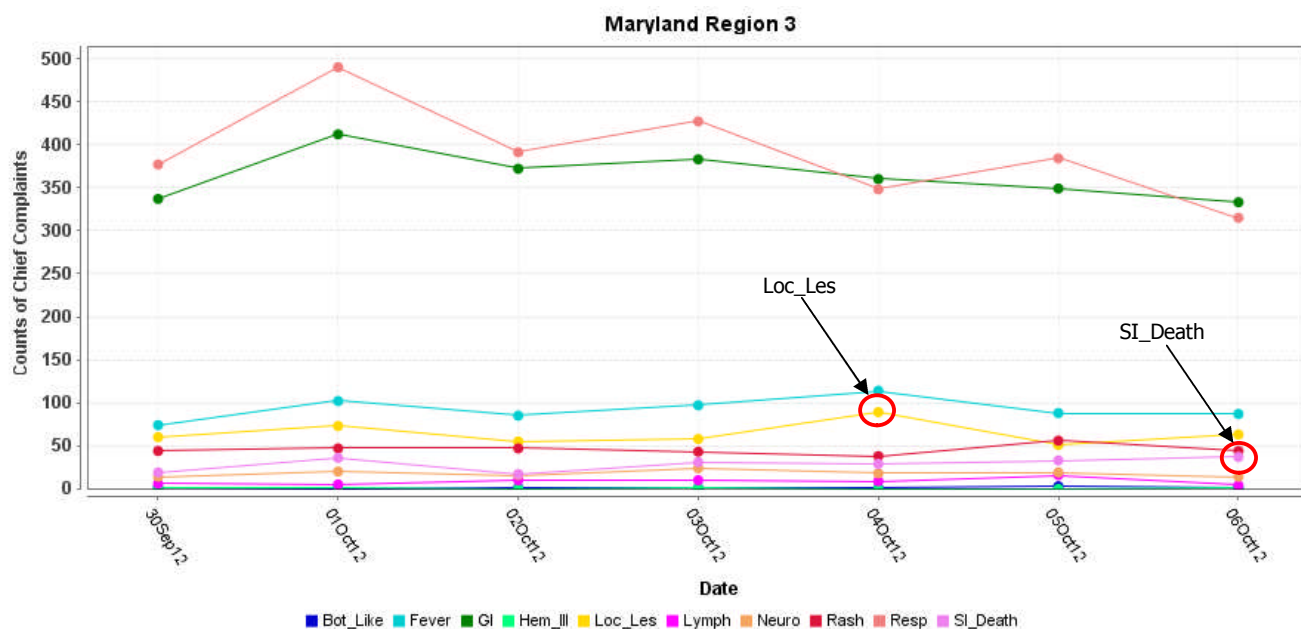


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

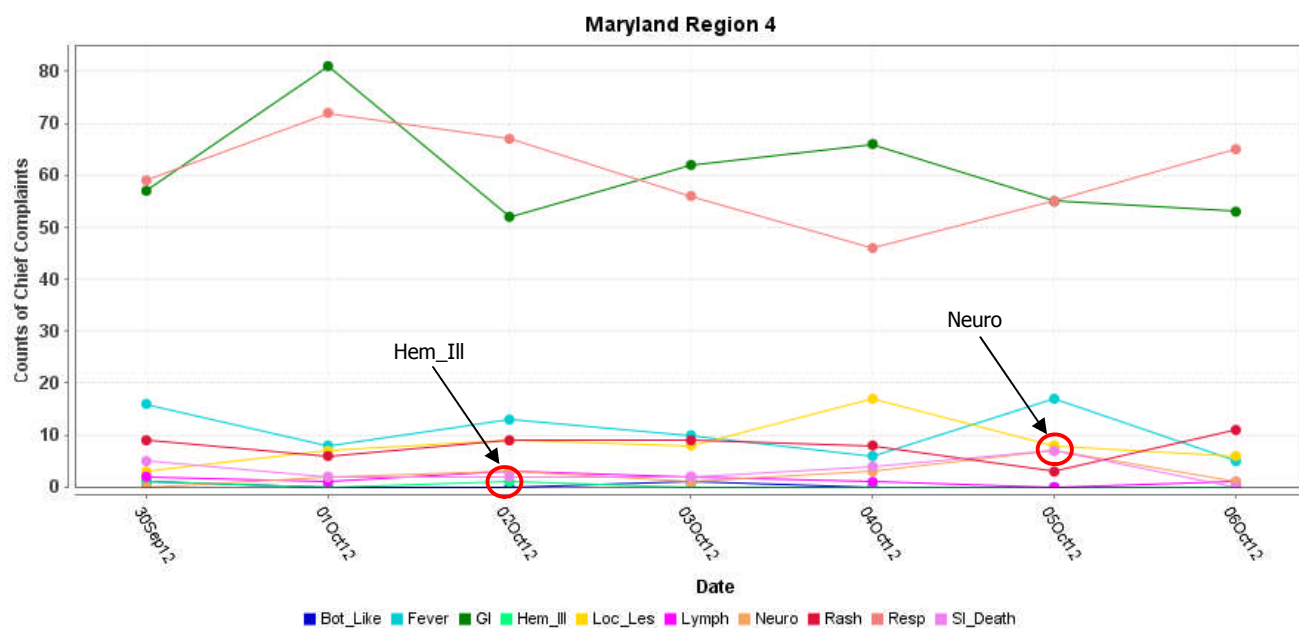
MARYLAND ESSENCE:



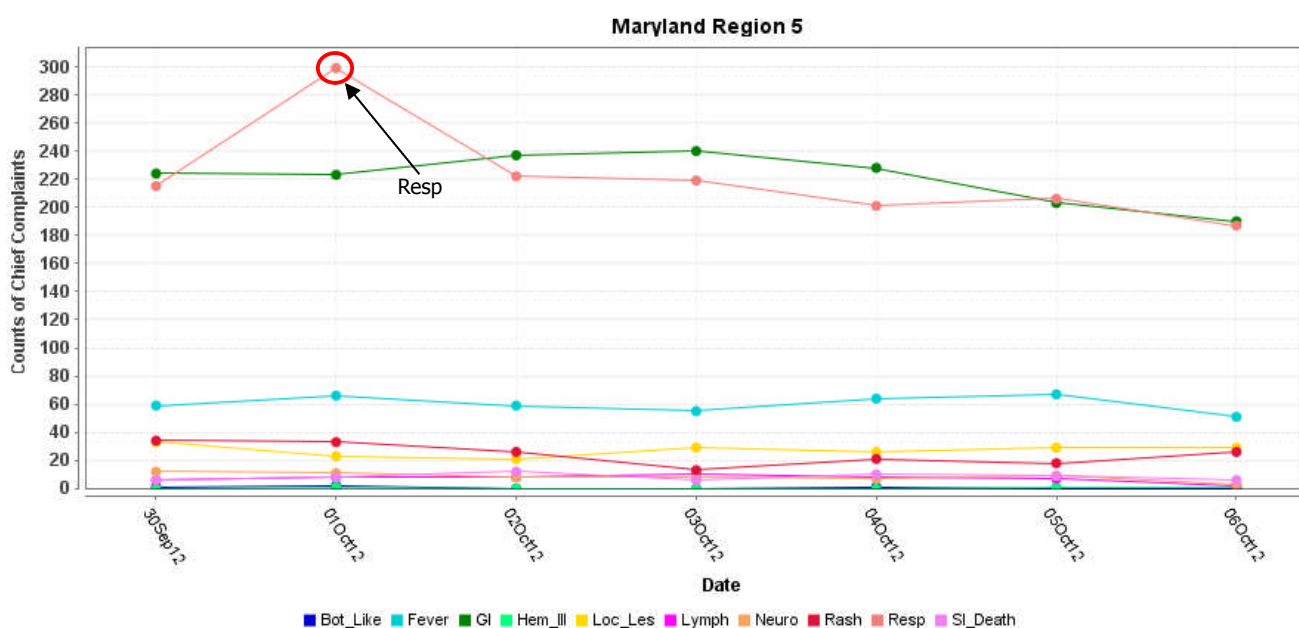
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE

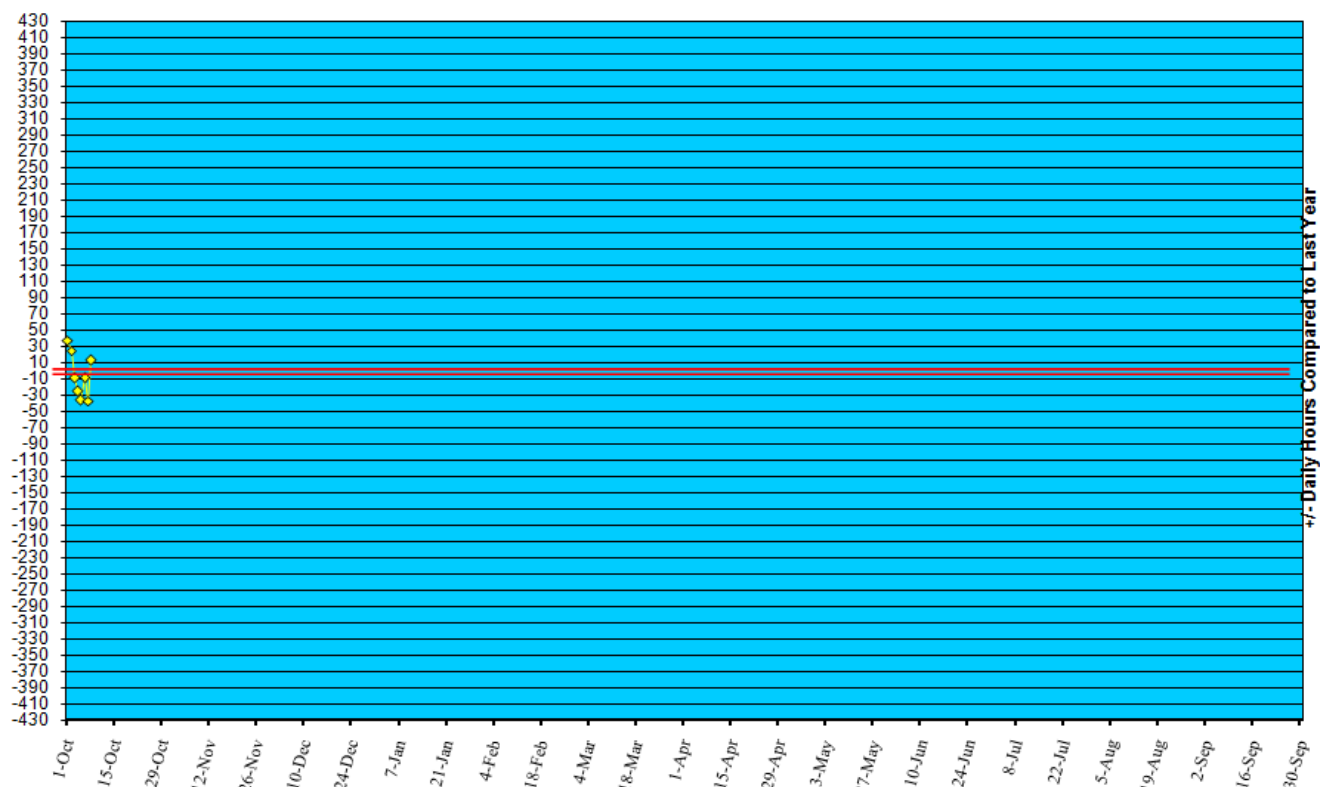


* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.

Statewide Yellow Alert Comparison Daily Historical Deviations October 1, '12 to October 6, '12



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in September 2012 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	<u>Aseptic</u>	<u>Meningococcal</u>
New cases (September 30 – October 6, 2012):	10	0
Prior week (September 23 – September 29, 2012):	14	0
Week#40, 2011 (October 2 – October 8, 2011):	16	0

3 outbreaks were reported to DHMH during MMWR Week 40 (September 30-October 6, 2012)

2 Rash illnesses outbreak

1 outbreak of SCABIES in a Nursing Home

1 outbreak of HAND, FOOT, AND MOUTH DISEASE associated with a Daycare Center

1 Other outbreak

1 outbreak of MENINGITIS associated with a Nationally Distributed Pharmaceutical Product

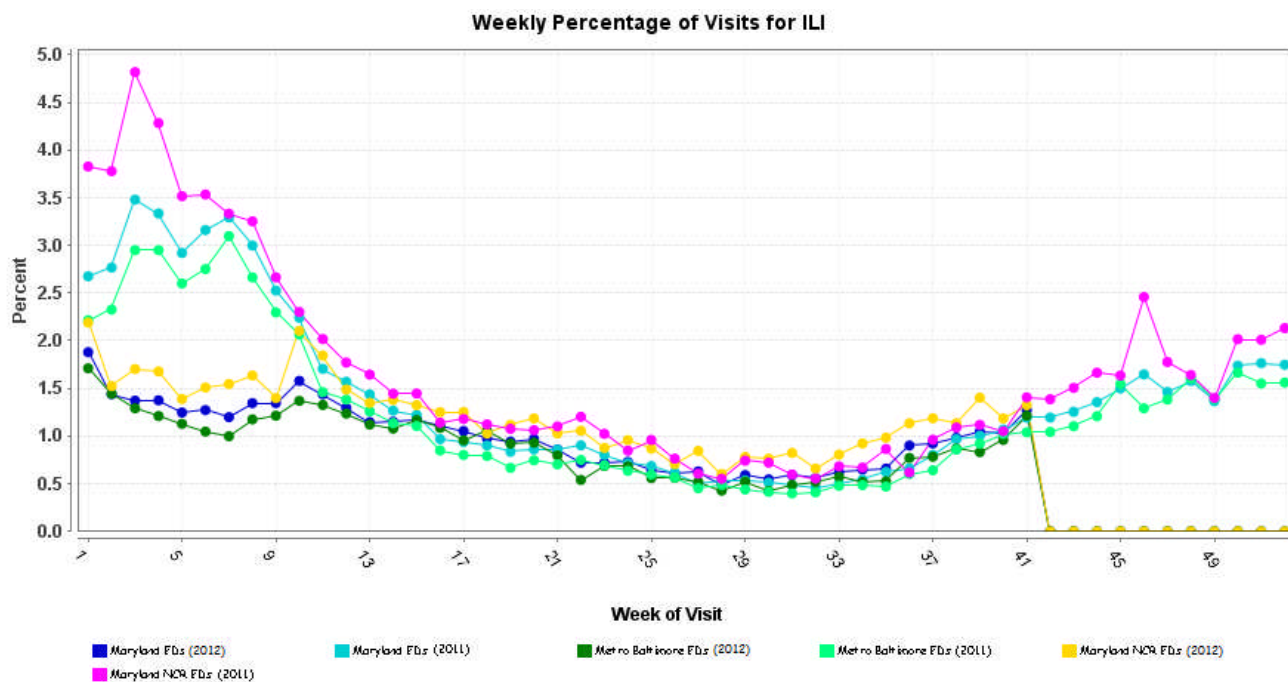
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 40 was: No activity.

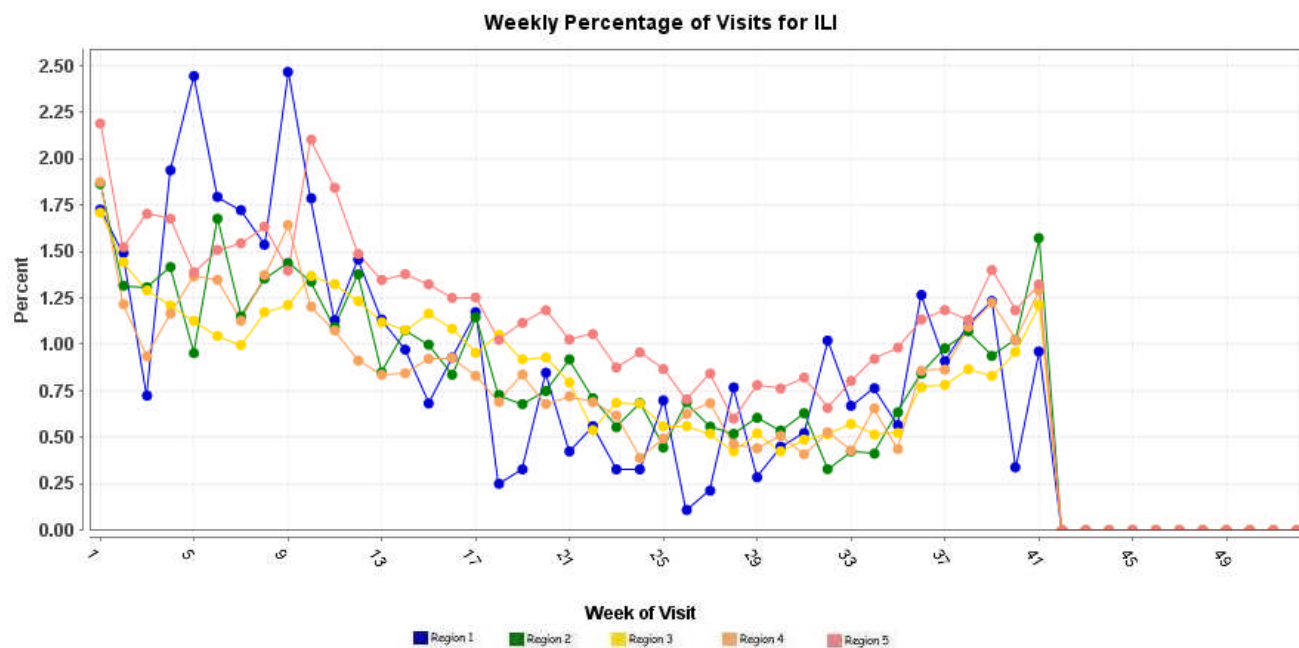
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



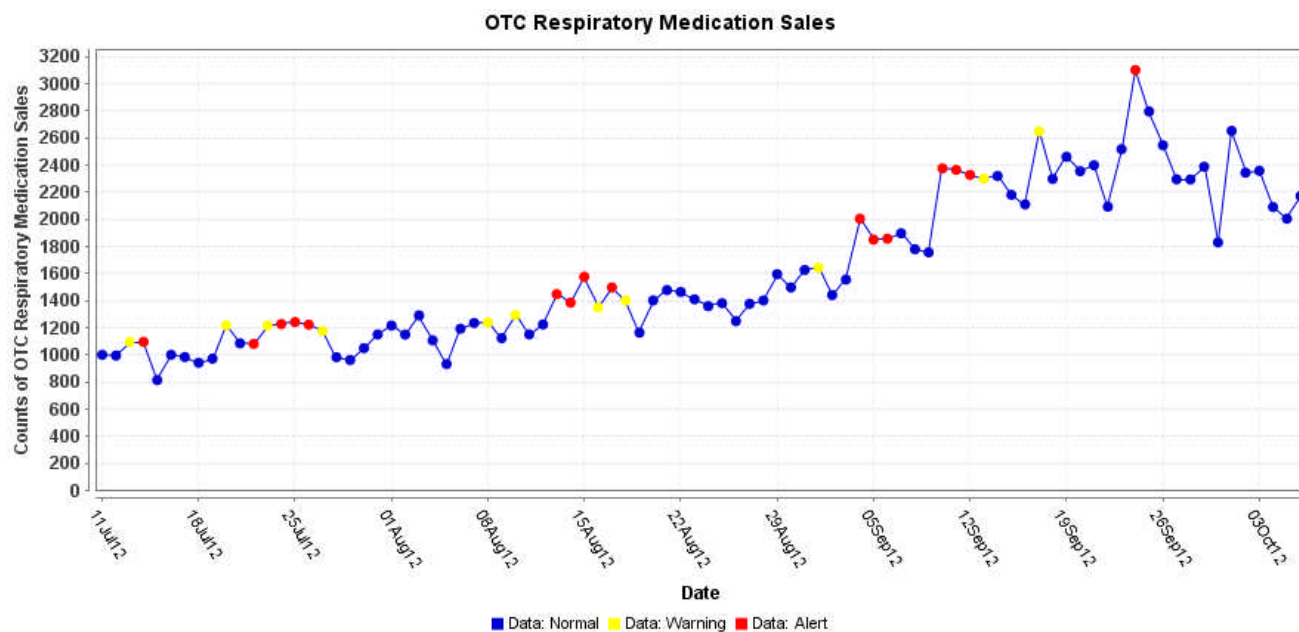
* Includes 2011 and 2012 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2012 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic. As of August 10, 2012, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 608, of which 359 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

NATIONAL DISEASE REPORTS*

SALMONELLOSIS, SEROTYPE BREDENEY (USA): 05 October 2012, The FDA says it has found salmonellae in a New Mexico plant that produces nut butters for national retailer Trader Joe's and several other grocery chains. The Trader Joe's peanut butter is now linked to 35 cases of salmonellosis in 19 states. The FDA said Fri 5 Oct 2012, that Washington state health officials have also confirmed the presence of salmonella in a jar of the Trader Joe's peanut butter found in a victim's home. Sunland Inc. has expanded its recall to include all products manufactured in the plant in the last 2.5 years, since March 2010. Whole Foods Market, Target, Safeway, and many other national chains have used Sunland products in their own brands. Almost 2/3 of those sickened are children under the age of 10. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS (USA, NETHERLANDS): 03 October 2012, CDC, FDA, and USDA are cooperating in an ongoing investigation of *Salmonella Thompson* illnesses that may be linked to a concurrent outbreak in the Netherlands. The US investigation began last month (September 2012) into 85 cases of a single genetic type of *S. Thompson* that were reported by 27 states since 1 Jul 2012, according to CDC spokesperson Lola Russell. 10 people have been hospitalized; there have been no deaths. This is a fairly common strain of *S. Thompson*, and CDC would normally expect to see approximately 30 "background" cases during the same period. The epidemiological investigation into the source of the 85 illnesses is being carried out by the various state health agencies in cooperation with CDC. It would not be surprising, according to CDC, if some of the 85 cases are found to be unrelated to the outbreak. CDC is not yet ready to release a list of the affected states; however, eFoodAlert has learned that the following states are in the process of investigating one or more *S. Thompson* illnesses:

Alabama: 1 case
Arizona: 1 case; a child
Colorado: 2 cases
Illinois: 2 cases
Maryland: 10 cases; age range 5 years to 77 years; most cases in the Baltimore metropolitan area
Nebraska: 6 cases; age range is 3 months to 61 years; 2 people hospitalized; illnesses reported from the east central region of Nebraska
New Hampshire: 1 case; an adult resident of Rockingham County who was hospitalized, but has since recovered
New York: 4 cases; no geographic cluster
Texas: 1 case
Virginia: 1 case

The outbreak strain appears to be the same as the strain that is behind the Dutch outbreak, and CDC is recommending that the public avoid eating smoked salmon originating from the Dutch producer. On 28 Sep 2012, the Dutch Food and Consumer Product Safety Authority announced the recall of smoked salmon manufactured by Foppen Paling en Zalm and sold through major supermarket chains, including Aldi and Albert Heijn. On 1 Oct 2012, the Netherlands issued an alert through the EU Rapid Alert System for Food and Feed, notifying member countries that a sample of smoked salmon originating from Greece was contaminated with *S. Thompson*. Associated Press reports that the contaminated smoked salmon was processed at Foppen's factory in Greece. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

GASTROENTERITIS (GERMANY): 06 October 2012, More than 11,000 German schoolchildren fell ill due to a deadly food poisoning outbreak, but the cause of the same was not known. It is now suspected that strawberries were the probable cause of the mass food poisoning, which led children to suffer from diarrhea and vomiting. The news was given by the Robert Koch Institute, which has told the German authorities that they have found a link between the occurrence of the outbreak and frozen batch of strawberries. Holger Eichele, spokesman for the Ministry of Food, Agriculture and Consumer Protection, was delighted to inform that they have been able to solve one of the biggest hurdles in the case. "We have made a big step forward in the investigations", he further asserted. Though majority of the patients have witnessed minor symptoms of food poisoning, like vomiting, still there are 32 people, who have suffering from serious consequences of the food poisoning and are being hospitalized. The caterer, who supplied the food to schools and kindergarten, has announced that they will be paying the compensations to parents. Further investigations in the matter are going on and is expected that authorities concerned will soon be able to reach at a conclusion. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (UNITED KINGDOM): 05 October 2012, A man critically ill with Crimean-Congo viral hemorrhagic fever (CCVHF) has been flown from Glasgow to London in a special RAF [Royal Air Force] isolation plane. The 38-year-old, who had been in Kabul, Afghanistan, was diagnosed hours after returning to Glasgow on Emirates flight EK027 from Dubai on Tuesday [2 Oct 2012]. He was transferred from the city's specialist Brownlee unit [Gartnavel Hospital] to the Royal Free Hospital in London on Friday morning [5 Oct 2012]. Passengers who sat near the man have

been contacted and have no symptoms. NHS Greater Glasgow and Clyde (GGC) said medical staff would continue to follow up with passengers on the flight from Dubai. The health authority said the risk to all other passengers was "extremely low" and advised anyone with concerns to contact NHS 24 [Emergency Telephone Service]. This is the 1st case of CCVHF in the UK. NHS GGC said the patient's transfer was "in line with the UK-wide protocol for the management of diseases of this severity and rarity." The man was stabilized overnight before being moved in specialist isolation facilities by air with the support of the Scottish Ambulance Service and the RAF. Public health consultant, Dr Syed Ahmed, who is coordinating the investigations into this case, said: "The risk of person-to-person transmission of Crimean Congo Viral Hemorrhagic Fever is extremely low as it can only be transmitted by direct contact with infected blood or body fluids. It is not a virus which is transmitted through the air. As such the risk to those who were in close contact with him is minimal. We have already made contact with all the patient's close contacts and they are being followed-up appropriately. The decision to transfer the patient to the high security unit at the Royal Free was taken in line with the national protocol for the management of cases such as this." The NHS 24 helpline number for anyone on flight number EK027 to call if they have concerns is 08000 85 85 31. The helpline will be available between 08:00 and 22:00, 7 days a week. CCVHF is a zoonosis -- a disease found in animals that can infect humans. Outbreaks are usually linked to contact with blood or body fluids from infected animals or people. Onset is sudden, with initial symptoms including high fever, joint pain, stomach pain, and vomiting. Red eyes, a flushed face and red spots in the throat are also common. As the illness progresses, patients can develop large areas of severe bruising, severe nosebleeds, and uncontrolled bleeding. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (PAKISTAN): 04 October 2012, A 2nd case of Crimean-Congo hemorrhagic fever (CCHF) from Rawalpindi was confirmed by the National Institute of Health (NIH) on Wednesday [3 Feb 2012]. Meanwhile, the World Health Organization (WHO) has warned against the increase in CCHF cases this year if precautionary measures are not taken before Eidul Azha. This year, 38 confirmed cases of CCHF have been reported from across the country and more are expected after Eidul Azha, according to the WHO. Out of these 38 cases, 14 deaths have been reported so far. This is the 1st time in 8 years that there has been such an increase in the number of CCHF cases in the country. According to the NIH, the case is from Choa Saidan Shah in Chakwal district from where a previous CCHF case was reported which resulted in the patient's death. The 45-year-old victim was brought to the Holy Family Hospital (HFH) Rawalpindi on 27 Sep 2012 with high-grade fever. His test samples were sent to the NIH where it was confirmed that he was infected with the deadly disease. Talking to The Express Tribune, HFH Deputy Medical Superintendent (DMS) Dr Javed Hayat said the latest patient is a butcher and is also associated with the leather business. He said his condition was stable and he would soon be discharged. A 65-year-old doctor, who had been brought earlier to the HFH, failed to survive because of massive blood loss. He was also associated with the leather business. Talking to The Express Tribune, WHO Focal Person for Vector Control, Dr Qutbuddin Kakar said there were chances of an increase in CCHF cases in the country, particularly in high-risk areas, if precautionary measures were not taken to deal with the influx of sacrificial animals in urban areas. Animals from endemic areas like Balochistan should be properly de-ticked before they are moved to from one place to other. "Considering the recent situation of CCHF cases in Pakistan, we are expecting more cases after Eid ul Azha," he said. Currently, lack of awareness is a major hurdle in combating the disease, Dr Kakar added. People should take precautionary measures while slaughtering sacrificial animals like wearing gloves, properly covering their face, especially eyes and mouth. Those who come into contact with newly-skinned animal hides should also take safety measures. Patients infected with the virus should be quarantined to prevent its spread through their secretions. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

EBOLA VIRUS DISEASE (UGANDA): 04 October 2012, The Ministry of Health (MoH), Uganda has declared today [4 Oct 2012], the end of the Ebola hemorrhagic fever (EHF) [Ebola virus disease] outbreak in Kibaale district. The last case was confirmed on 3 Aug 2012 and was discharged from the hospital on 24 Aug 2012. This is double the maximum incubation period (21 days) for Ebola as recommended by WHO. In the outbreak, a total of 24 probable and confirmed cases were recorded, of which 11 were laboratory confirmed by the Uganda Virus Research Institute (UVRI) in Entebbe. A total of 17 deaths were reported in this outbreak. National and District Ebola Task Forces were coordinated by the MoH to respond to the outbreak. MoH worked closely with WHO and other agencies which included the African Field Epidemiology Network (AFENET), EMESCO Foundation (a local NGO), Infectious Diseases Institute (IDI), Uganda Red Cross Society (URCS), Medecins Sans Frontieres (MSF), the United Nations Children's Fund (UNICEF), US Centers for Disease Control and prevention (CDC), US Agency for International Development (USAID). WHO also coordinated with the Global Outbreak Alert and Response Network (GOARN) to support the response operations. The response activities carried out during the outbreak included enhanced surveillance for early case detection and contact tracing, reinforcement of infection prevention and control including case management in isolation facilities using barrier nursing and conducting supervised safe burials, reinforcement of standard precautions in health care settings, and enhancing communication interventions at the national and community levels. A team led by CDC conducted ecological studies in Kibaale district to try and understand the likely source and route of transmission of the virus. Samples from bats, primates and livestock were collected to study the possible source of the Ebola virus and putative initial human infection from wildlife. The Ebola response teams have continued to educate the community on prevention, detection of, and early reporting of any suspected cases in future. Health workers in the district have been trained on prevention of health care associated infections. WHO does not recommend that any travel or trade restrictions be applied to Uganda with respect to this event. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from <http://www.promedmail.org/>.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: <http://preparedness.dhmm.maryland.gov/>

Maryland's Resident Influenza Tracking System: <http://dhmm.maryland.gov/flusurvey>

NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

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Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	<p>ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)</p> <p>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus</p> <p>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis</p> <p>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain</p> <p>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE <i>acute exacerbation</i> of chronic illnesses.)</p>	<p>Anthrax (inhalational)</p> <p>Tularemia</p> <p>Plague (pneumonic)</p>
Neurological	<p>ACUTE neurological infection of the central nervous system (CNS)</p> <p>SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis</p> <p>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS</p> <p>ACUTE non-specific symptoms of CNS infection such as meningismus, delirium</p> <p>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's</p>	Not applicable
Rash	<p>ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)</p> <p>SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox</p> <p>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem</p> <p>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea</p> <p>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema</p>	Smallpox
Specific Infection	<p>ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)</p> <p>INCLUDES septicemia from known bacteria</p> <p>INCLUDES other febrile illnesses such as scarlet fever</p>	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Fever	<p>ACUTE potentially febrile illness of origin not specified</p> <p>INCLUDES fever and septicemia not otherwise specified</p> <p>INCLUDES unspecified viral illness even though unknown if fever is present</p> <p>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome</p>	Not applicable
Severe Illness or Death potentially due to infectious disease	<p>ACUTE onset of shock or coma from potentially infectious causes</p> <p>EXCLUDES shock from trauma</p> <p>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births</p> <p>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths</p>	Not applicable